

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if no residence before admission) or STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>GERTRUDE</u> First <u>LEDERER</u> Middle <u>LEDERER</u> Last		4. DATE OF DEATH <u>JUNE 16</u> Month <u>1956</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28, 1895</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Max Wickerhauser</u>		14. MOTHER'S MAIDEN NAME <u>Magdaline Haselmayer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Dr. Kufst Lederer, Hillsboro, Md.</u>	
17. INFORMANT <u>Dr. Kufst Lederer, Hillsboro, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the breast</u> DUE TO <u>Carcinoma of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>53</u> , to <u>Dec 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12 June</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.		DATE SIGNED <u>June 17, 1956</u>	
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 18, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Hillsboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hugh Keenelton</u> ADDRESS <u>Greenmount</u>		24a. REC'D BY REGISTRAR DATE <u>6/18/56</u>	
24b. REGISTRAR'S SIGNATURE <u>N.H. Neer</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 27 1956

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07049

6906

CERTIFICATE OF DEATH

Reg. Dist. No.

64

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>		d. STREET ADDRESS <u>Nichols</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nichols</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>R.</u> Last <u>Nichols</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Caroline Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Nichols</u>		14. MOTHER'S MAIDEN NAME <u>Emily Edgell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-36-5649</u>	
17. INFORMANT <u>Mrs. Anna M. Nichols, Federalsburg, Md., R.F.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>H.C.V.D.</u> DUE TO (c) <u>Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Mon</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia, mild</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-27, 1956</u> to <u>6-29, 1956</u> , that I last saw the deceased alive on <u>6-29, 1956</u> , and that death occurred at <u>9:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.C. Kingsbury</u>		M.D. <u>Federalsburg, Md.</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>7/3/56</u>	
PHYSICIAN'S NAME (Type) <u>R. C. Kingsbury, M.D.</u>		<u>Federalsburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 3, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>		ADDRESS <u>Federalsburg, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>July 3, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05994

6007

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH o. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>Lillian</u> Middle <u>Nichols</u> Last				4. DATE OF DEATH <u>June 24</u> Month <u>June</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 6, 1869</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Moore</u>				14. MOTHER'S MAIDEN NAME <u>Gafie Phillip</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hubert Moore</u>		Address <u>Denton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>422X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio Vascular Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 days - 5 yrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> 19 <u>56</u> , to <u>June 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 23</u> , 19 <u>56</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Danforth George</u> M.D.				DATE SIGNED <u>June 24, 1956</u>			
PHYSICIAN'S NAME (Type) <u>DANFORTH GEORGE MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 27, 1956</u>		<u>Denton</u>		<u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hubert Moore, Denton, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Wm S G. George</u>	

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BUREAU V. 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1 6008

CERTIFICATE OF DEATH

05995

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural	c. LENGTH OF STAY IN 1b full life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural near Andersentown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		d. STREET ADDRESS R.F.D.	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Linda D. Passwaters		4. DATE OF DEATH Month June Day 4 Year 1956	
5. SEX Fem.	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1883
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Md. Caroline Co.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Willis E. Liden	
14. MOTHER'S MAIDEN NAME Martha Noble		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. yes		17. INFORMANT Earl W. Passawters Address Federalsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170x DUE TO Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 55 , to June 4 , 19 56 , that I last saw the deceased alive on 6-3 , 19 56 , and that death occurred at 1.10 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Dawson O. George M.D.		ADDRESS (Street, city or town, state) Dintons Md DATE SIGNED 6/5/56	
PHYSICIAN'S NAME (Type) DAWSON O. GEORGE			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF June 7, 1956	22c. NAME OF CEMETERY OR CREMATORY Bloomery Cemetery	22d. LOCATION (City, town, or county) (State) near Federalsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harvey Williams ADDRESS Federalsburg, Md.		24a. REC'D BY REGISTRAR DATE June 6, 1956	24b. REGISTRAR'S SIGNATURE Everett Nattle, Deputy Registrar

MEDICAL CERTIFICATION

[illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05996

Reg. Dist. No. *led*

6009

1. PLACE OF DEATH o. COUNTY <i>Caroline</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Goldsboro</i>				c. LENGTH OF STAY IN 1b <i>85 Yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>				d. STREET ADDRESS <i>None</i>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Oliver Byard Reed</i>				4. DATE OF DEATH Month <i>6</i> Day <i>25</i> Year <i>1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/8/1871</i>	
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farm Owner</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>James W. Reed</i>				14. MOTHER'S MAIDEN NAME <i>No Record</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Nancy Whitham Townsend, Del.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremic Poisoning</i> <i>794X</i> DUE TO <i>Exhaustion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Left Side Hemiplegia</i> (c) <i>1957</i>				INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i> <i>2 yrs</i> <i>1957</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <i>01</i> p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>1957</i> , to <i>6/22</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Apr 1956</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>H F Silver</i> M.D.				ADDRESS (Street, city or town, state) <i>Greensboro Md</i>			
DATE SIGNED <i>6/24-56</i>							
PHYSICIAN'S NAME (Type) <i>H F Silver</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/28/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Greensboro</i>		22d. LOCATION (City, town, or county) (State) <i>Greensboro, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulais</i>				ADDRESS <i>Greensboro, Md.</i>			
24a. REC'D BY REGISTRAR DATE <i>6/26/56</i>				24b. REGISTRAR'S SIGNATURE <i>AL Smith</i>			

RECEIVED

6010

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Caroline</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		c. LENGTH OF STAY IN TB <i>25 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>LOIS</i> First <i>EUNICE</i> Middle <i>STAFFORD</i> Last		4. DATE OF DEATH <i>June 14</i> Month <i>14</i> Day <i>1956</i> Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 28, 1905</i>
9. AGE (In years last birthday) <i>50</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Lee M. Seymour</i>		14. MOTHER'S MAIDEN NAME <i>William L. Ewing</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Clifford L. Stafford, Denton</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brain tumor - Glioblastoma multiforme</i> 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>19 mo.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 20</i> , 19 <i>55</i> , to <i>June 14</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>June 13</i> , 19 <i>56</i> , and that death occurred at <i>5:40 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. Paul Knotts</i>		DATE SIGNED <i>6-16-56</i>	
PHYSICIAN'S NAME (Type) <i>E. Paul Knotts</i>		<i>Denton, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>June 17, 1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Denton</i>	22d. LOCATION (City, town, or county) (State) <i>Denton, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Virgil Hoover, Denton</i>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Wm D. [Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 20 1923		MOBILE, ALABAMA	
RACE		COLOR		RELIGION		MARRIED		SINGLE	
WHITE		WHITE		METHODIST		MARRIED		MARRIED	
OCCUPATION		EDUCATION		SCHOOLING		SCHOOLING		SCHOOLING	
CONDUCTOR		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
JAN 20 1968		MOBILE, ALABAMA		HEART DISEASE		NATURAL		NATURAL	
TIME OF DEATH		HOURS		MINUTES		SECONDS		SECONDS	
10:00 PM		10		00		00		00	
DATE OF BURIAL		PLACE OF BURIAL		CEREMONY		CEREMONY		CEREMONY	
JAN 22 1968		MOBILE, ALABAMA		METHODIST		METHODIST		METHODIST	
DATE OF INTERMENT		PLACE OF INTERMENT		CEREMONY		CEREMONY		CEREMONY	
JAN 22 1968		MOBILE, ALABAMA		METHODIST		METHODIST		METHODIST	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CEREMONY		CEREMONY		CEREMONY	
JAN 20 1968		MOBILE, ALABAMA		METHODIST		METHODIST		METHODIST	
DATE OF SIGNATURE		PLACE OF SIGNATURE		CEREMONY		CEREMONY		CEREMONY	
JAN 20 1968		MOBILE, ALABAMA		METHODIST		METHODIST		METHODIST	

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JAN 19 1968

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6211
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro		c. LENGTH OF STAY IN 1b 59 Yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Henry Last Wright		4. DATE OF DEATH Month 6 Day 25 Year 1956	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/1896
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theador Wright		14. MOTHER'S MAIDEN NAME Lizzie Tilman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-30-2295	
17. INFORMANT Lydia Wright Greensboro, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis Cardiovascular Dis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 24 , 1956, to June 25 , 1956, that I last saw the deceased alive on June 25 , 1956, and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 6/26/56			
ACTUAL SIGNATURE Charles H. Stonestfer M.D.			
PHYSICIAN'S NAME (Type) Charles H. Stonestfer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/28/56	22c. NAME OF CEMETERY OR CREMATORY Union	22d. LOCATION (City, town, or county) (State) Goldsboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Boulais		ADDRESS Greensboro, Md.	
24a. REC'D BY REGISTRAR 4/27/56		24b. REGISTRAR'S SIGNATURE L. M. Pippin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of medical examiner	
13. Signature of funeral director		14. Signature of coroner		15. Signature of health officer	
16. Signature of registrar		17. Signature of informant		18. Signature of medical examiner	
19. Signature of funeral director		20. Signature of coroner		21. Signature of health officer	
22. Signature of registrar		23. Signature of informant		24. Signature of medical examiner	
25. Signature of funeral director		26. Signature of coroner		27. Signature of health officer	
28. Signature of registrar		29. Signature of informant		30. Signature of medical examiner	
31. Signature of funeral director		32. Signature of coroner		33. Signature of health officer	
34. Signature of registrar		35. Signature of informant		36. Signature of medical examiner	
37. Signature of funeral director		38. Signature of coroner		39. Signature of health officer	
40. Signature of registrar		41. Signature of informant		42. Signature of medical examiner	
43. Signature of funeral director		44. Signature of coroner		45. Signature of health officer	
46. Signature of registrar		47. Signature of informant		48. Signature of medical examiner	
49. Signature of funeral director		50. Signature of coroner		51. Signature of health officer	
52. Signature of registrar		53. Signature of informant		54. Signature of medical examiner	
55. Signature of funeral director		56. Signature of coroner		57. Signature of health officer	
58. Signature of registrar		59. Signature of informant		60. Signature of medical examiner	
61. Signature of funeral director		62. Signature of coroner		63. Signature of health officer	
64. Signature of registrar		65. Signature of informant		66. Signature of medical examiner	
67. Signature of funeral director		68. Signature of coroner		69. Signature of health officer	
70. Signature of registrar		71. Signature of informant		72. Signature of medical examiner	
73. Signature of funeral director		74. Signature of coroner		75. Signature of health officer	
76. Signature of registrar		77. Signature of informant		78. Signature of medical examiner	
79. Signature of funeral director		80. Signature of coroner		81. Signature of health officer	
82. Signature of registrar		83. Signature of informant		84. Signature of medical examiner	
85. Signature of funeral director		86. Signature of coroner		87. Signature of health officer	
88. Signature of registrar		89. Signature of informant		90. Signature of medical examiner	
91. Signature of funeral director		92. Signature of coroner		93. Signature of health officer	
94. Signature of registrar		95. Signature of informant		96. Signature of medical examiner	
97. Signature of funeral director		98. Signature of coroner		99. Signature of health officer	
100. Signature of registrar		101. Signature of informant		102. Signature of medical examiner	

RECEIVED
JUL 2 1956
BUREAU V. S.